

FILED SEP 13 1944

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

27676

State File No. \_\_\_\_\_

Registration District No. 114

Primary Registration District No. 4186

Registrar's No. 34

1. PLACE OF DEATH:

(a) County FRANKLIN

(b) City or town SULLIVAN  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: \_\_\_\_\_  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)

In this community LIFE years, months or days

3. (a) PRINT FULL NAME FORREST MCGLOTHLIN

3. (b) If veteran, name war NO 3. (c) Social Security No. NONE

4. Sex MALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Carrie McGlothlin 6. (c) Age of husband or wife if alive 65 years

7. Birth date of deceased Jan. 5 1874  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>70</u>	<u>7</u>	<u>25</u>	hr. _____ min.

9. Birthplace Franklin Co. Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation Farming

11. Industry or business Farming

12. Name William McGlothlin

13. Birthplace Cole Co. Missouri  
(City, town, or county) (State or foreign country)

14. Maiden name Clara Berriembach

15. Birthplace Berk Co. Penn.  
(City, town, or county) (State or foreign country)

16. (a) Informant W. G. McGlothlin

(b) Address 5433 Union Ave. St. Louis, Mo

17. (a) Burial (b) Date thereof Sep. 2, '44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Crow Cemetery

18. (a) Signature of funeral director Robert Shaffer  
(b) Address Sullivan, Missouri

19. (a) 9-2-44 (b) Robert Shaffer  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Franklin

(c) City or town Sullivan  
(If outside city or town limits, write "RURAL")

(d) Street No. \_\_\_\_\_ (If rural, give location)

(e) If foreign born, how long in U. S. A.? 0 years.

MEDICAL CERTIFICATION

August 30

20. DATE OF DEATH: Month Aug. day 30  
year 1944 hour 4 minute 30 P. M.

21. I hereby certify that I attended the deceased from 8-24  
1944 to 8-26 1944  
that I last saw him alive on 8-26 1944  
and that death occurred on the date and hour stated above.

Immediate cause of death Septicemia Duration 2 days

Due to Chronic Myocarditis  
arteriosclerosis

Other conditions 938  
(Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

(b) Date of occurrence \_\_\_\_\_

(c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature D. O. Garner (M. D. or other) D.O.  
Address Sullivan Mo. Date signed 9-2-44

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER, FATHER

RECEIVED

District Health Officer No. 9,

District File Number \_\_\_\_\_

Date Filed \_\_\_\_\_

9-12-44

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by \_\_\_\_\_

\_\_\_\_\_, Registered Apprentice No. \_\_\_\_\_  
working under my personal supervision.

Signed \_\_\_\_\_

*Edgar W. Laffrow*

Licensed Embalmer No. \_\_\_\_\_

3394

P. O. Address \_\_\_\_\_

*Sullivan, Mo*

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, above space should be left blank.**